

Centers for Medicare & Medicaid Services  
Special Open Door Forum:  
Quality Improvement Organization Beneficiary Protection Program  
Thursday, October 30, 2008  
2pm-3:30pm ET  
Conference Call Only

The Centers for Medicare & Medicaid Services (CMS) will host this Special Open Door Forum (ODF) to discuss improvements to the Quality Improvement Organization (QIO) Beneficiary Protection Program (BPP). The BPP incorporates several QIO functions, including quality of care reviews, reviews of beneficiary complaints, higher-weighted Diagnostic Related Group reviews, utilization reviews, early readmission reviews, EMTALA reviews, appeals of discharges from various provider settings (fee for service and Medicare Advantage), and hospital preadmission reviews. The purpose of this Special ODF is to gain insight regarding changes and improvements needed to the regulations governing the QIO program, specifically 42 CFR Parts 475, 476, 478, and 480. The feedback will facilitate CMS' efforts to make the BPP more transparent to stakeholders, increase the effectiveness of QIOs in improving the quality of health care, and ensure the QIO regulations accurately convey all current legal requirements.

This Special ODF will focus on the following areas of the BPP:

- Beneficiary Complaint Reviews
- Quality of Care reviews
- Transparency
- Process Requirements for QIO BPP functions

As CMS moves forward on transforming the Beneficiary Protection Program, additional Forums may be scheduled based on need.

We look forward to your participation.

OPEN DOOR FORUM INSTRUCTIONS:

*\*\*Capacity is limited so dial in early. You may begin dialing into this forum as early as 1:45 PM ET.\*\**

Dial: 1-800-837-1935

Reference Conference ID 67947865

Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880 and for Internet Relay services click here <http://www.consumer.att.com/relay/which/index.html> . A Relay Communications Assistant will help.

An audio recording of this Special Forum will be posted to the Special ODF website at [http://www.cms.hhs.gov/OpenDoorForums/05\\_ODF\\_SpecialODF.asp](http://www.cms.hhs.gov/OpenDoorForums/05_ODF_SpecialODF.asp) and will be accessible for downloading beginning November 6, 2008 and available for 30 days.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit our website at: <http://www.cms.hhs.gov/OpenDoorForums/>

Thank you.

Questions for October 30<sup>th</sup>: Special Open Door Forum:

Quality Improvement Organization Beneficiary Protection Program

In preparation for the October 30<sup>th</sup> Special ODF: Quality Improvement Organization Beneficiary Protection Program, below are the four topics, explained in more detail, that CMS is asking for your feedback. Please keep your responses under two minutes for each question.

We look forward to your participation.

1. Beneficiary Complaint Reviews

In accordance with §1154(a)(14) of the Social Security Act, QIOs are responsible for conducting reviews of written complaints filed by beneficiaries about the quality of services not meeting professionally recognized standards of health care. This responsibility has not been previously detailed in regulation. Please provide feedback regarding specific requirements you believe should be added to the QIO program regulations regarding beneficiary complaint reviews.

2. Quality of Care Reviews

In accordance with §1154(a)(1)(B), QIOs conduct quality of care reviews to determine whether services meet professionally recognized standards of health care. Provisions are included in current regulations detailing the process QIOs must follow in completing these reviews, and currently reviews are based solely on the medical record. Additionally, these regulations have not been updated in decades and CMS is evaluating opportunities to modify current process requirements and improve the effectiveness of the QIO program through these reviews. Please provide feedback regarding changes that could be made to the regulations related to quality of care reviews that could improve the effectiveness of these reviews.

3. Transparency

In accordance with §1154(a)(14), QIOs must inform beneficiaries of the final disposition of complaints. At a minimum, QIOs must advise beneficiaries whether care did or did not meet professionally recognized standard(s) of care, and CMS is evaluating ways to increase the amount of information conveyed to beneficiaries as a result of beneficiary complaint. Please provide feedback regarding the types of information that should be provided to beneficiaries in the final disposition of complaints in addition to whether care did or did not meet professionally recognized standards of care. Also provide feedback on ideas for ensuring we are capturing the totality of quality of care complaints from Medicare beneficiaries.

4. Process Requirements for QIO BPP functions

42 CFR Parts 475, 476, 478, and 480 detail various functions performed by QIOs. In addition to issues surrounding beneficiary complaint reviews, quality of care reviews, and transparency, are there ways to rearrange or change the regulations that will make them more user-friendly and readable and facilitate stakeholders' understanding of the QIOs' responsibilities and the effectiveness of QIOs in improving the quality of health care.

Audio file of this transcript:

[http://media.cms.hhs.gov/audio/SpcODF\\_QIOProgRegs.mp3](http://media.cms.hhs.gov/audio/SpcODF_QIOProgRegs.mp3)

CENTERS FOR MEDICARE AND MEDICAID SERVICES

Special Open Door Forum:  
Quality Improvement Organization Beneficiary Protection Program

Moderator: Natalie Highsmith  
Conference Leader: Tom Kessler  
October 30, 2008  
2:00 pm ET

Operator: Good afternoon. My name is (Amanda) and I will be your conference facilitator today. At this time I would like to welcome everyone to the Centers for Medicare and Medicaid Services Special Open Door Forum on Quality Improvement Organization Beneficiary Protection Program.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks there will be a question and answer session. If you would like to ask a question during this time simply press star then the number 1 on your telephone keypad. If you would like to withdraw your question press the pound key.

Thank you. Ms. (Vandalay Highsmith) you can begin your conference.

(Vandalay Highsmith): Thank you (Amanda). Good day to everyone and thank you for joining us. The purpose of the Special Open Door Forum is to discuss improvements to the Quality Improvement Organization Beneficiary Protection Program.

CMS wants to gain your insight regarding the changes and improvements needed to the regulations governing the QIO program, which will make the Beneficiary Protection Program more transparent to stakeholders, increase QIO effectiveness and ensure the QIO regulations convey all current legal requirements.

The focus of the call will be on the following four areas - beneficiary complaint review, quality of care review, transparency, and process requirements for QIO Beneficiary Protection Program functions.

We sent out a list of a little more detail of the topics on the list serve yesterday and they just have a little bit more detail for each topic and they will be posted on the Special Open Door Forum Web page.

I will now turn the call over to (Derek King) who is the Deputy Director of our Office of Clinical Standards and Quality. (Derek).

(Derek King): Thank you very much. First of all good afternoon to everyone. I'm looking at the clock so I guess even on the West coast a good afternoon and I'm looking forward to getting some sense of how many individuals are on the line or at least how many lines are open. Hope we have a pretty broad audience for this discussion because this is an area of extreme importance to us and I'm sure to all those on the line.

I'm here today to talk quite a bit, or it's going to be a short dialog from my end about our quality improvement organization and at least a part of what the QIO's, as affectionately known by us here at the Center of Medicare and Medicaid Services or what they do in terms of beneficiary protection and more than talking about what they do to hear from you about some areas that we're going to pinpoint that we really want to improve upon in terms of the services that they provide.

The goal of this forum as we kind of settle and go right between the eyes as to what we want to get out of this is to hear from you. But in order for you, from my perspective, to really to be able to give us the kind of feedback that we need I need to tell you first what areas within beneficiary protection we really want to modify or redesign.

First of all when I think about the beneficiary protection program and the pieces and parts that we're looking at, just kind of highlight the functions for you real quickly, so and for many of you on the line who are technical experts in this area, just bear with me for a moment as we talk about our functions within our review process.

Our quality of care reviews cover a couple areas, beneficiary complaints to really speak to the heart of our beneficiaries of patients who within whatever setting are concerned about the quality of care received.

We are the focal point for where the quality improvement organizations, where those complaints come to and some are on the line, and may not have this basic understanding that the QIOs, which service every state, and receive complaints from all across the continental United States as well as of course, Alaska, Hawaii and their territories, as they receive those complaints they respond as to the validity of those complaints.

We also cover high awaited diagnostic-related group reviews, utilization reviews, early admission reviews and then this one area that I find of particular interest EMTALA which is say within that Emergency Room we just can't turn individuals away but they have, or we have as a healthcare system a responsibility to stabilize and at least

diagnose what the issue is for anybody who comes in, so the EMTALA reviews.

The appeals of discharges from various provider settings for fee for services for Medicare Advantage and hospitals pre-admission reviews as well. So you take all that kind of globally, the big area is the complaint process. So as we look at our complaint process what is it that we want to touch on? Well many of the things within our program already reviewed a precursor of our assessment of the program, have come to us over the past several years.

One being the Institute of Medicine who took a look at the program and produced a report back in '06, March of '06 where they talked about the QIO program and talked about ways where we might maximize the potential of this tremendous infrastructure that we have in place to address our healthcare concerns.

And they put forward several recommendations on how to change the program. But on every review and assessment that the IOM does many times either simultaneous or prior to, or certainly on the heels of those reviews we take our own internal assessment.

Starting August 1st of this year we launched a new contract, three-year contract for the quality improvement organizations and really moved the program in different direction on a thematic way to address several issues ranging from patient safety to care transition, prevention, and beneficiary protection is a major foundational piece of what we call this the ninth contract for the Quality improvement organizations.

We would have loved to be able to go into this particular contract with a plan in place for how we wanted to revise, modify, redesign and

improve that program. But we were unable to do that, but what we are able to do is to be inclusive of those of you on the line who are stakeholders, customers, representative organizations of those beneficiaries that we serve and to include you in the process to hear your perspective of how we might grapple with several key issues, and let me just give you some sense of what they are.

First of all, one of the things that we realized that there may be some legal requirement to change is a frustration that many beneficiaries have around transparency or the lack thereof in this process. So let's look at this from the perspective of a patient and their family and not having recently been in that particular situation can view this quite easily.

Where the quality of care received from my perspective and for many of yours and those you represent was sub-par and you file a complaint and that complaint goes to the QIOs and maybe there's some justification in your complaint that it goes to several different places, because it's not only quality of care that was an issue but it may be sub-par in terms of a facility itself. So you have several different reasons to complain.

At the end of the day you want enough information so that you know exactly what occurred and what rights you have to rectify the situation if at all possible. There are parameters around what the QIOs can and cannot say back to that patient, back to that family, back to those concerned parties about the quality of care or lack thereof received.

So one of the things we want to hear from you has to do with your expectations and even though we have to work within the confines of statute and our rules, still as we go into the process of looking at what it



is we want to change or what it is will be about the business of recommending in terms of change, it'll be great to be able to have that discussion with as a backdrop your concerns clearly identified. So transparency or the lack thereof is a critical issue.

So as we look at that process please give us your perspective to that end. Another key issue for us has to do with the fact that many individuals that we talk to do they really even know that this process exists. And how we might do a better job in our beneficiary protection program of not just getting the word out but ensuring that other individuals that patients have, beneficiaries are clear about the rights that they have.

The fact that this process does exist, the fact that there is a process in place of being clear on what they have to do, and then once they send us this information that says I have a complaint, we also have a responsibility not just at a high level but at an operational level to ensure that the quality improvement organizations who are contracted with the Center of Medicare and Medicaid Services, our contractors, respond in a timely basis because being that patient or support system for a patient going through this process, you want to make sure you get your information back in a timely basis.

So that once again you're able to engage the healthcare industry, engage that hospital in a dialog that moves the process forward in terms of your complaint and that's another critical, critical piece.

Another piece that we know we want to talk about internally just so you have some perspective from our standpoint, the quality improvement organizations as I alluded to earlier, they not only handle the complaints and higher weighted DRGs, and all those pieces around

what I call case review, but they're also the premier consultants, if you will, to the healthcare system to inform and help educate them and bring them along to improve the quality of service that they provide.

So they perform quality improvement as well as this quality control activity. And what we want to be able to do and any insights that you have of ways that we can connect individual complaints with broader quality improvement initiatives to link these parts of our program, that would also be quite helpful.

No how do we do this? After it's all said and done and we get your ideas and we have our own ideas and we look at what the Institute of Medicine has had to say about this, at the end of the day it's a regulation, it's a rule that has to take place, a QIO regulations that really drives this process at the end of the day.

So there has to be a process at the end of the day where our set of rules that govern our program say okay, now that we know what we want to do based on the perspective of those we serve, based on the perspective of those that we were with, now we can put pen to paper to say here's what this process is going to look like.

So we really encouraged a dialog today, a conversation, communication and let much of it be one way from you to us. We don't want to spend a lot of time describing in the weeds what our program is about because much of that time would be not wasted time but certainly wouldn't be as valuable as hearing from you.

This is my view of your program, this is my view of what the quality improvement organizations do today, this is what I think about the timeliness of the program and what we can do to improve it. This is

what I think in terms of what needs to happen around the transparency of our program.

This is what I think is lacking in issues around the QIOs really informing in this program and a kind of a transparent way being knowledgeable in the minds of those that are served in the hospital arena. Do people know this exists and we want you to give us a perspective on all those?

Now we were able to structure them around these four points of beneficiary complaints and quality of care reviews and transparency process requirements. But at the heart is what I just said. Tell us what you think of our program. Not just at a high level but more importantly help us land this issue so that we can begin to formulate the change that we have in mind.

One other piece I'll give you -- at some point in this process we'll hope to come back, we'll plan to come back and give you some sense of how the feedback that you collectively have given us, how helpful it has been and so I'm really hoping we have a rigorous dialog today that leads to changes and improvements needed to the regulations governing the QIO program.

And I want to thank you once again for spending breakfast time to talk with us about our program, which we care an awful lot about, and the fact that you're on the line today to talk to us briefly just echoes the fact that you deem this program extremely important as well. And so thank you once again.

(Vandalay Highsmith): Thank you (Derek). And now I will turn the call over to Tom Kessler.

Tom Kessler: Hi. I did want to note that if you're unable to comment specifically during this open door forum today, don't worry we have set up an e-mail address dedicated to our goal of transforming the Beneficiary Protection Program and we will gladly review any comments you want to forward to us after the conclusion of this forum. The e-mail address is currently functioning and the e-mail address is [bpp\\_transformation@cms.hhs.gov](mailto:bpp_transformation@cms.hhs.gov). Again that's [bpp\\_transformation@cms.hhs.gov](mailto:bpp_transformation@cms.hhs.gov).

And now we look forward to reviewing your comments on this initiative and we begin the question and response section of the forum.

Woman: Okay the first question that we are looking to get your feedback on is beneficiary complaint review. QIO's are responsible for conducting reviews of written complaints filed by beneficiaries about the quality of services not meeting professionally recognized standards of healthcare. This responsibility has not been previously detailed in regulations. Please provide feedback regarding specific requirements you believe should be added to the QIO program regulations regarding beneficiary complaint reviews.

So now (Amanda) is you could just remind everyone on how to get into the queue to ask their question and please remember to restate your name, the state you are calling from, or provider or organization you are representing and please keep your responses to under two minutes and we will take about ten minutes worth of feedback on this one question. (Amanda)?

Operator: At this time as a reminder if you wish to ask a question please press star and then 1 on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

The first question is from (Josh Evans) from Washington, D.C. Your line is now open.

(Josh Evans): Hi. And actually I apologize, this isn't a comment or question directly related to the answer your question. I was just curious if there was, if you guys were going to have a document that outlines the questions you're asking say on the phone so that we can address these through written comments.

Woman: We sent the questions out on the list serve yesterday...

(Josh Evans): Okay. I must not have (unintelligible) that list serve then.

Woman: And they will also be posted on a special open door forum Web page by Monday.

(Josh Evans): By Monday. Thank you very much.

Woman: You're welcome.

Operator: At this time nobody else is in queue.

Woman: Okay. Then I guess there is no one out there who wants to give their feedback on the first question so we'll move to the second question which is quality care review. QIOs conduct quality of care reviews to determine whether services meet professionally recognized standards of healthcare. Provisions are included in current regulations detailing

the process QIOs must follow in completing these reviews and currently reviews are based solely on the medical record.

Additionally, these regulations have not been updated in decades and CMS is evaluating opportunities to modify current process requirements and improve the effectiveness of the QIO program through these reviews. Please provide feedback regarding the changes that could be made to the regulations related to quality of care reviews that could improve the effectiveness of these reviews.

We're going to take questions on this question only. (Amanda)?

Operator: Again, if you'd like to ask a question please press star and then 1 on your telephone keypad. We'll pause for just a moment to compile the Q&A roster.

The first questions from (Tina Stack) from Colorado. Your line is now open.

(Tina Stack): Thank you all for eliciting some feedback on the subject. I think from an oversight perspective it isn't clear and you're absolutely right, they use a medical record. And I think the attitude or what we've seen when we send complaints is that if the hospital didn't write about the occurrence in the records and the occurrence did not exist and I went through this through a review process actually for my own mother that had a bad outcome in a facility.

And so the other oversight piece is to allow the time to the QIO to actually look into these cases and perhaps also decrease the time frame in which the review gets done. It was a multiple, probably six-month

process to get some kind of outcome which probably is not you know, an actionable item for a hospital to make some changes on.

Operator: Thank you. The next person in queue is from (Alison Ready) from Massachusetts. Your line is now open.

(Alison Ready): Hi. And again thank you also for the opportunity to comment. I wondered if the regulation should be including you know, standards around (interegulated) reliability, how electronic medical records should be handled and going back to the other caller, the idea of action plans and the time frame for resolution of those action plans.

Operator: Thank you. The next person in queue is from (Lars Madison) from California. Your line is now open.

(Lars Madison): I had a question about response time from (Lumetra) which is what we use in California. It appears sometimes that the person who can answer a specific question about use of HINN letters or other issues related to discharge of the patient who's appealing that, it kind of depends on who is available. Is there a contact at CMS we can use if (Lumetra) is not giving us the answers timely?

Man: I, for now if you want you could submit your issue to the [bpp\\_transformation@cms.hhs.gov](mailto:bpp_transformation@cms.hhs.gov) e-mail address and we'll try to funnel that to the appropriate entity.

(Jim Foyer): And yeah, this is (Jim Foyer). Please send the issue and not any beneficiary identifiable information as the QIO is through statute entitled to collect that protected information and protected information that goes to CMS is protectionally liable to a Freedom of Information Act request. So we want to make sure that we be sure the privacy and

the confidentiality of the beneficiary level of information. So thank you.

Operator: Thank you. The next person in queue is (Claire Curry) from Virginia. Your line is now open.

(Claire Curry): Thank you very much for the opportunity to comment. I'm work with the Consumer Advocacy Group trying to improve long-term care here in central Virginia. And one of my frustrations was getting the quality of care reviews information QIO in Virginia seems to feel its hands are tied to work with the Consumer Advocacy Group and they're very reluctant to share information about their quality of care, whatever data they collect.

And I think that the regulations need to be strengthened so that the quality of care information is more accessible and that there is a regulatory requirement for them to cooperate with advocacy groups and folks working to improve quality of care.

Operator: Thank you. There's currently nobody else in queue. Actually it looks like somebody just came into queue. (Denise Lucienz) from Pennsylvania your line is now open.

(Denise Lucienz): Yes. Thank you for the opportunity. My question or comments revolve around readmission reviews as far as quality and payment. And in the Medicare Program Integrity Manual it's not real clear how readmissions are reviewed by the FI and as they're referred to the QIO. And in one of the sections it says, "The contractor shall refer all readmission cases selected as part of the medical review to the QIO."



And as far as information goes, like what those reviews will be, what's being looked for, that to me, that information is not clear anywhere. The Federal Registry it's not clear. Again in the integrity manual it's not clear. So I think as a hospital we're out here unknown what, you know, it used to be premature discharges but where is that all spelled out so that when I'm asked I know what you're looking at?

Man: Okay. Thank you. We've written that down and we'll certainly look into that as part of this process.

(Denise Lucienz): Thank you very much.

Operator: Thank you. The next person in queue is from (Cheryl Lahane) from Massachusetts. Your line is now open.

(Cheryl Lahane): Hello. And we agree with the previous comments about the timing of review in relation to the beneficiary complaint process that that, if we could shorten up that length of time that it takes I think people would be more satisfied with the process.

And also as far as the process as the QIO with the complaint it would be I believe it would be beneficial to be able to share with the provider that it is a complaint-related review right up front, like right when we're repressing the medical record so that everyone can be kind of on the same page right from the beginning.

Operator: Thank you. The next person in queue is from (Elaine Eakin). Your line is now open, from California.

(Elaine Eakin): Hello. I have two questions and a comment and thank you again for this opportunity for us to get some feedback. I'm calling from

California like the gentleman earlier and I've heard that the QIO will change from (Lumetra) to Health Services Advisory Group but I haven't seen anything official and this is supposed to happen November 1st, that's in a few days.

My second question is whether patients, we've heard a few cases throughout California, patients who go to a hospital they're not admitted and they're placed under observation for more than two days, one case was nine days, another case 14 days. How does the QIO get involved in cases like that?

And I have a comment about a patient or the beneficiary outreach and education when I give presentations on this a lot of people, many people in the audience would say you know, when I'm a patient I'm really too sick to advocate for myself. So I guess a comment is to let people know to get their families involved, their friends involved so that when they're in the hospital and too sick somebody else can be advocating on their behalf.

Woman: Thank you. Even though we're in listening mode I do want to give you some information to clarify the situation as it pertains to beneficiary case review in California. Currently the QIO in California doing beneficiary case review is (Lumetra). During the contract process (Lumetra) was not chosen to be the (ninth) critical core contractor, however they are protesting that decision and that process will play out in sometime certain.

Once there is, if there is a change or once there is a change in a contractor in that area for beneficiary case review we will make you aware of that through our Web site and the other venues that we currently use. Does that help?

(Elaine Eakin): Yes it does. I'm just you know, concerned because of the day I heard and that why there's still no news. So what you're telling me is it's actually still uncertain.

Woman: There is no date that we've been given. I think that's probably a rumor that's been circulating. People like the first of the month for some reason.

(Elaine Eakin): Okay. Thank you. Yeah that does help with that question.

Operator: Thank you. The next person in queue is (Shirley Redmond) from Arkansas. Your line is now open.

(Shirley Redmond): My statement kind of, I think might include number one and number two regarding beneficiary complaint reviews and quality of care reviews. It seems that very often we get phone calls from beneficiaries or even written complaints where it's pretty obvious that their problem is not going to be confirmed in a medical record.

But we can't offer any sort of facilitated resolution or any assistance without going through the entire medical record review process, which is time consuming and very expensive.

And with the budgets being the way they are it just seems to make more sense if we could possibly just be a facilitator to those beneficiaries with the provider or the practitioner and just be a go between and have that be entered into (unintelligible) some way where we could get credit for being helpful and in the process save a lot of money and time. Thank you.

Tom Kessler: Okay. Thank you very much. This is Tom Kessler and again we'll certainly take that comment into consideration.

Operator: Thank you. The next person in queue is (Tina Snap) from Colorado. Your line is now open. (Tina Snap) from Colorado your line is now open.

(Tina Snap): I'm sorry. Thank you for making, letting me make an additional comment. One thing the consistency with the QIO determination...

Woman: I'm sorry. (Tina) can you get a little closer to the microphone please, we cannot hear you.

(Tina Snap): Sure. The consistency with the QIO determination and the actual conditions of participation that molding of the two regulations together would be helpful.

And then I don't know if this is the right place but oversight with managed care companies, I think we see more managed care Medicare and they really have no back up or advocacy from the QIO because the quality reviews are to be sent to the actual payer and they don't have any voice of the QIO level, the other thing are benefit determinations with the managed care, Medicare's that do not allow for example acute rehab and benefits that they would normally get under Medicare and they're appeal rights regarding that.

Operator: Thank you. The next person in queue is (Darlene Perkins) from Massachusetts. Your line is now open.

(Darlene Perkins): Hi. Thank you for letting me speak. Our concern, we are an advocacy group, and our concern is that we have people who complain that

either things that they don't want in their records or problems are not put in their records in hospitals and nursing homes. So it's hard to be able to trace the complaint if it's not put in the record.

We also, I just would like to add one more thing, we were a little late at the first question, and I know this is only this question, but I know with our QIO in our state there's been major budget cuts so the outreach to let people know where to go to make a complaint is being cut, their outreach has been cut I think completely, I'm not sure, their education anyway. So that's going to be even less people that are going to know where to go to get help with these problems. Thank you.

Operator: Thank you. The next person is (Denise Phillips) from Oregon. Your line is now open.

(Denise Phillips): Yes. This comment applies to both (bene) complaint reviews and quality of care reviews. I concur with a couple of other folks that mentioned about the timing that we could cut time frames to make it better customer service for beneficiaries and even for hospitals to know about our decisions and one instance for example is just even having to wait 30 days to get the medical record.

Other opportunities to respond along the way where you have 20 days here and then you have 30 days here, you have additional days people don't, like 15 extra days if they don't submit all of their documentation and it adds up quite a bit and one thing in particular that would be helpful is if a hospital refuses for example to give us a medical record for a patient, we can deny payment, I mean this isn't, they don't make a habit of this and this is nothing critical at all of our hospitals in Oregon.

But we do run in periodically where we struggle with obtaining the medical record from the physician's office and we have to involve our project officer and even that we've had offices say we don't have the record and for whatever reason, and we have, there's not teeth in this to deny payment saying you know, if they don't come up with the record.

So there are lots of things, I guess my summary comment would be we could really tighten time frames by which receipt asking for information from providers in terms of the medical records, the time period that they have to respond, even the 30-day disclosure period I think we could shorten all of those up.

And I'd also like to see more teeth that if practitioners don't or even other providers besides hospitals don't give us the medical records and the documentation we need to conduct the review that there's some sort of financial teeth attached to that. Thank you.

Woman: Okay (Amanda) we're going to take our final question or our final comments on question number two.

Operator: There is actually nobody else in queue at this time ma'am.

Woman: Okay. Great. We're going to the third feedback topic which is transparency. QIO's must inform beneficiaries of the final disposition of complaints . At a minimum QIO's must advise beneficiaries whether care did or did not meet professionally recognized standards of care and CMS is evaluating ways to increase the amount of information conveyed to beneficiaries as a result of beneficiary complaints.

Please provide feedback regarding the types of information that should be provided to beneficiaries in the final disposition of complaints in addition to whether care did or did not meet professionally recognized standards of care. Also, provide feedback on ideas for ensuring we are capturing the total, the totality of quality of care complaints from Medicare beneficiaries.

So we are taking feedback comments on question number three on transparency.

Operator: Just as a reminder, if you wish to ask a question please press star and then 1 on your telephone keypad. The first person is (Katie Ricks) from Maryland. Your line is now open.

(Katie Ricks): Actually my comment was on the last question and I wanted to reinforce what the lady from Virginia said. We are an advocacy group involved with long-term care state-wide in Maryland. The QIO operations as far as nursing homes are concerned, we see no, we see no benefits to them. We see nothing because they are so non-transparent we can't figure out what they're doing. We do know a few cases where they, we have found out that they have worked with nursing homes and those nursing homes they're shown no improvement.

We really feel that we need to have a citizen review board or some mechanism whereby we can have those beneficiaries directly involved in some of these regulation processes so that we will be then included more fully in the result.

Operator: Thank you. The next person in queue is (Michele Johnson) from Virginia. Your line is now open.

(Michele Johnson): Thanks. As far as transparency, I'm speaking on behalf of the American Health Quality Association representing QIOs and we think it would be helpful that patients want to know not only whether they're concern involved a quality of care problem but what happened and most importantly what was done to fix that problem. So we think that that would go a lot farther towards actual transparency. Thank you.

Operator: Thank you. The next person in queue is from (Darlene Perkins) from Massachusetts. Your line is now open.

(Darlene Perkins): Hi. Well we'd like to kind of follow-up with what the person in front of us was just saying that there should be, or actually the first two people, that there should be more than one person that receives, we also work with nursing homes.

So sometimes maybe the person who, the beneficiary would receive the information of what was done and the person that actually cares for them, their healthcare proxy or their guardian we don't believe they get a letter so if both of them got a letter we would be able to maybe follow-up better and know if there was action taken and what the action was. Thank you.

Woman: Thank you.

Operator: Thank you. The next person is (Shirley Redmond) from Arkansas. Your line is now open.



(Shirley Redmond): We did a review where a person had to have their leg amputated because of the poor wound care that they received at the facility but our letters make us say that the care met professional recognized standards of healthcare unless the care was gross and flagrant, and I questioned other QIOs around to see what their wording was and it seems like it kind of depended on the QIO of that state and what their board of directors decided and all that.

And it was real difficult to be telling them, the family of this beneficiary that care met standards when obviously they didn't, but that was the way our wording was. And so a suggestion that I would come up with is that CMS kind of you know, they give us the letters that we send out basically and it would be nice that if every QIO said the same thing, if you have a confirmed quality of care issue it shouldn't be meeting professionally recognized standards of care. Thank you.

Woman: Thank you.

Operator: Thank you. The next person is (Nancy Blackburn) from Tennessee. Your line is now open.

(Nancy Blackburn): My question, and my statement is really sort of framed in a question, and that is how much information is getting to the beneficiary about the functioning relative to their needs of the QIOs. And the reason I ask this, the QIOs are interested primarily in quality, however from the beneficiary standpoint medical necessity to them almost translates into quality of care.

And are there any efforts made or shouldn't there be efforts made to bring these two together so that the beneficiary has a better

understanding of what is pure quality of care and what is medical necessity.

Woman: Thank you.

Operator: Thank you. The next person is (Tina Snap) from Colorado. Your line is now open.

(Tina Snap): I really appreciate the comments on the recognized standards of care because I think that is very confusing to somebody that knows that something went terribly wrong with something that happened to them in the hospital. The letters themselves I think are a bit confusing to the beneficiaries on how the decision was rendered.

And then also I think something left off is the source document and source references of who they spoke with in the facilities and who gave input into the decision review. I think it seems it's quite secretive in the letters so I think the beneficiary would probably feel better if they knew who actually looked at a case and how they came up with that and the clarity in which that's delivered to them.

Woman: Thank you.

Operator: Thank you. The next person is (Claire Curry) from Virginia. Your line is now open.

(Claire Curry): Hi. Thank you for the opportunity to comment. I'm speaking in a bigger sense in terms of the transparency of what QIO is doing in terms of (congregate) information that would show patterns and make more public accessible information about you know, how many complaint are being investigated and what are the results.

And that might show patterns of whether or not they're being effective in their, and thorough in their investigations if we could just have aggregate data that showed the number of complaints, where they were made and all of that.

Woman: Thank you.

Operator: Thank you. As a reminder if you wish to ask a question please press star and then 1 on your telephone keypad.

There's currently no one else in queue.

Woman: Okay. We will go ahead and move onto our fourth and final feedback question which is process requirements for QIO BPP functions. 42 CFR Parts 475, 476, 478 and 480 detailed various functions performed by QIOs.

In addition to issues surrounding beneficiary complaint reviews, quality of care reviews and transparency, are there ways to rearrange and change the regulations that will make them more user-friendly and readable and facilitate stakeholders understanding of the QIO's responsibilities and the effectiveness of QIO's in improving the quality of healthcare.

So we are taking feedback on question number four process requirements for QIO BPP functions.

Operator: Once again, as a reminder if you wish to ask a question please press star and then 1 on your telephone keypad.

Our first person is (Elaine Nelson) from Arizona. Your line is now open.

(Elaine Nelson): Thank you. Actually we called to comment on number three, transparency. For the QIO's the inability to notify the beneficiaries of findings of our reviews is probably one of the most frustrating things that we encounter on a daily basis. Currently the regulations do not allow full disclosure of findings regarding physician quality of care concerns unless the physician agrees to allow that type to occur which does not happen very often.

In addition, we are restricted from notifying the beneficiary of any findings regarding issues that we identify during the course of our review unless the beneficiary brought that incident to our attention. We would love to see the transparency increased on those type of findings and would hope that you can help us with that in the future. Thank you for this opportunity.

Woman: Thank you.

Operator: Thank you and once again as a reminder if you wish to ask a question please press star and then 1 on your telephone keypad.

Woman: We will go ahead and take questions, take feedback on all four questions - beneficiary complaint reviews, quality of care reviews, transparency and process requirements for QIO BPP functions, so it's no longer itemized for each question, we're going to take questions and comments from all of the questions.

Operator: It looks like the first person in queue is (Michael Clode) from Iowa. Your line is now open.

(Michael Clode): Hello and thank you too for taking this call. I'd like to suggest that around the provider termination notices that home health agencies and skilled nursing facilities issue when they're terminating Medicare benefits that CMS require the QIOs or someone, perhaps even at CMS, to disclose the data about reversals of those provider termination decisions.

Some QIO's, and I'm thinking off hand that the Kansas Foundation for Medical Care, puts that stuff on their Web sites. Other QIOs do not. It's not readily accessible on CMS's Web site, and I just mention this that in contrast to some of Medicare's appeals contractors in original Medicare that there's just a big glaring difference there where with the appeals contractors a lot more information is available about reversal rates and the types of decisions that are being made.

So I just want to offer that by way of transparency and also your processes.

Operator: Thank you. Then next person in queue is (Darlene Perkins) from Massachusetts. Your line is now open.

(Darlene Perkins): Hi. We were discussing that we thought it would be helpful if the facility that had these complaints within them would post them somewhere maybe a bulletin board or somewhere so that people that people that were coming into the facility or someone who had a problem would see how many quality of care issues are actually complained about and what the resolutions are and if they are resolved. Thank you.

Operator: Thank you. The next person in queue is (Michele Johnson) from Virginia. Your line is now open.

(Michele Johnson): Yes I just had a question about the timing. I thought that I heard (Tara's) talk about a rule and I wondered what the time frame for that was.

Man: At this point we don't have a time frame and there actually is no rule. We're currently in the process of just obtaining feedback and frankly evaluating that feedback once we receive it to identify the path that we're going to take regarding transforming the program.

(Michele Johnson): But do you anticipate a rule-making process?

Man: Anticipate, yes. But anything more precise than that at this point it's just not available.

(Michele Johnson): Okay. Thanks.

Operator: Once again, if you'd like to ask a question please press star and then 1 on your telephone keypad.

The next person in queue is (Tina Snap) from Colorado. Your line is now open.

(Tina Snap): I just want to say again I think what the QIO's are saying are true on the other end and it's very frustrating when they can't disclose information that they know is what the real findings were.

From the consumer side of that, again I've lived this with my mother, you know, you can sense the frustration on the QIO side because they

knew something happened and that statement going back to the recognized standards of care you know, to be able to lift some of that restriction I think would give the beneficiaries much more satisfaction in the whole process. Thank you.

Woman: Thank you.

Operator: Thank you. The next person in queue is (Edward Williams) from Maryland. Your line is now open.

(Edward Williams): Hi. I just wanted clarification of what the gentleman said before we were stating that the, there's no time frame. I was under the impression that the time frame for processing of grievances and complaints was 30 days, 30 days from the start of the reception of the complaint or grievance.

Man: No my question actually, my response was directed to a time frame associated with a proposed rule. And at this point there is no proposed rule so there's no time frame associated with a proposed rule. So...

(Edward Williams): Oh okay. Understood. Understood. Thank you.

Operator: Thank you. The next person is (Cheryl Lahane) from Massachusetts. Your line is now open.

(Cheryl Lahane): Hi. This is related to the beneficiary complaint process at the end in the disclosure process if the complainant was the beneficiary themselves there's a requirement that we ask the physician involved in their care if there's, if he feels that there would be harm to the beneficiary if they were to receive the information.

In our experience with that has not been well-received by the beneficiary when the physician does in fact say that that patient should not get information about themselves and then we have to ask the patient to appoint or to let us know who we can send that letter to. And it's just a source of, the patient just feels disrespected and we feel that that process if that could be lifted and we would be able to communicate directly to that beneficiary who had the ability to contact us in the first place with their complaint.

So if that could be removed we think that would be an improvement to the process.

Woman: Thank you.

Man: Thank you.

Operator: Thank you. The next person in queue is (Carly Elliot) from South Dakota. Your line is now open.

(Carly Elliot): Hi. Thank you for asking for comments. And mine was just in regard to transparency of the process and of the program. And I think a lot of times when these complaints come up beneficiaries and others receive a lot of negative feedback or they feel that negativity because of the event that occurred with them.

But there are a lot of positive steps that occur within a hospital setting and within the medical staff as well to resolve those complaints to work through them and try and improve, and so maybe part of the communication back to the beneficiary could highlight some of those more positive elements that the facility does have a quality program.



They do have a patient advocate or a risk management individual that there is a peer review process in place as far as the medical staff goes so they don't lose complete faith in a provider that they may have seen at the facility or the facility in general.

And in our state there are a lot of communities that have a single facility and so if we start posting all of these quality concerns outside of our door things like that, the perception from the community and from the public may be very negative when in fact some of the complaints there may not be quality of care issues there or there are things that can be improved upon but again to try and promote that learning perspective and that improvement perspective and not necessarily focus on all of the negatives.

So those are the only comments I had, thank you.

Woman: Thank you.

Operator: Thank you. The next question in queue is from (Debbie Fizak) from Mississippi. Your line is now open. Or Michigan, sorry about that.

(Debbie Fizak): Yeah hi. I'm from Michigan here. Thank you for taking our feedback. I'd like to bring up one thing. As of late we've gotten some complaints that have been maybe ten to 20 years old. And based on the manual the patient was covered with Medicare at that time. So I'd like to have you think about maybe looking at some time frames. It's very difficult sometimes to get charts from 1980s and maybe set some sort of time frame (unintelligible) we can go to do specific complaints. Thank you.

Man: Thank you.

Operator: Thank you. The next question in queue from (Mary Breckenridge) from Texas. Your line is now open.

(Mary Breckenridge): Thank you for allowing us to comment. I have, my comment...

Woman: (Mary) can you get closer to the microphone please?

(Mary Breckenridge): ...(unintelligible) information for the public of beneficiaries. I don't really have a problem with that information being posted but I do think it needs to be put in categories so that a complaint that was invalid, people could see that maybe someone did complain but it turned out not to be a valid complaint. Just to say that you had 50 complaints I think could be very negative.

Woman: Thank you.

Operator: Thank you. At this time nobody else is in queue but this is a reminder if you wish to ask a question please press star and then 1 on your telephone keypad.

At this time there are no other questions in queue.

Woman: Okay. I will turn the call over to (Jean Woody-Williams) who is the Director of the Quality Improvement Group in our Office of Clinical Standards and Quality.

(Jean Woody-Williams): We'd just like to stop and thank you for taking the time to provide your feedback to us. I want to assure you that we have recorded and listened to everything that you've said and we'll definitely take it under advisement as we go about trying to transform the program on the behalf of beneficiaries. We want to remind you that

this is not the last opportunity that you have and if you have questions that you think are (unintelligible) conclusion of this call or you didn't feel comfortable asking on this call, please remember the e-mail address which again is [bpp\\_transformation@cms.hhs.gov](mailto:bpp_transformation@cms.hhs.gov). Thank you and we look forward to hearing from you.

Woman: (Amanda) can you tell us how many people joined us on the phone line?

Operator: (348).

Woman: (848). Thank you.

Operator: This concludes today's conference call. You may now disconnect.

END